Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY PUBLIC

August 4, 2023

[redacted], LEGAL ENTITY
DIAKON LUTHERAN SOCIAL MINISTRIES
ONE SOUTH HOME AVENUE
TOPTON, PA, 19562

RE: THE BUEHRLE CENTER
ONE SOUTH HOME AVENUE
TOPTON, PA, 19562
LICENSE/COC#: 21496

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/27/2023, 06/28/2023 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *THE BUEHRLE CENTER* **License #**: *21496* **License Expiration**: *07/24/2023*

Address: *ONE SOUTH HOME AVENUE, TOPTON, PA 19562*

County: *BERKS* **Region**: *NORTHEAST*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *DIAKON LUTHERAN SOCIAL MINISTRIES*

Address: *ONE SOUTH HOME AVENUE, TOPTON, PA, 19562*

Phone: **Email**:

Certificate(s) of Occupancy

Type: *C-1* **Date**: *01/16/2016* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *87* **Waking Staff**: *65*

Inspection Information

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *06/28/2023*

Inspection Dates and Department Representative

06/27/2023 - On-Site:

06/28/2023 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *92* **Residents Served**: *63*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *n/a* **Capacity**: *26* **Residents Served**: *24*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *62*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *24* **Have Physical Disability**: *1*

Inspections / Reviews

06/27/2023 Full

Lead Inspector: **Type**: *POC Submission* **Follow-Up Date**: *07/30/2023*

07/31/2023 - POC Submission

Submitted By: **Date Submitted**: *08/03/2023*

Reviewer: **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *08/03/2023*

Inspections / Reviews *(continued)*

08/04/2023 Document Submission

Submitted By: [redacted]
Date Submitted: *08/03/2023*
Reviewer: [redacted]
Follow Up Type: *Not Required*

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

License inspection summary reports dated 6/8/22, 2/8/23, and 4/4/23 were not posted in the home as required.

Plan of Correction ***Accept (- 07/31/2023)***

1. The personal care home immediately posted the updated current license summary for review.
2. The CSM or designee will update the current license summary binder within 24 hours upon exit of DHS from the facility. PCHA and CMS were provided education on July 27, 2023 that current license summary binder must be updated upon every DHS visit.
3. Jessica Musser, CSM will update current license summary binder with every visit from DHS.
4. Target completion Date: September 5, 2023
5. PCHA or designee will audit current license summary binder weekly x 4, then monthly x2, or until substantial compliance is achieved. Corrective action plan will be monitor through QAPI process.

Licensee's Proposed Overall Completion Date: *09/05/2023*

Implemented (- 08/04/2023)

15a - Resident Abuse Report

2. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

Resident #1 slapped Resident #2's arm on . The local area agency on aging was not notified regarding the alleged abuse.

Plan of Correction ***Accept (- 07/31/2023)***

1. The missed notification cannot be retroactively corrected.
2. The CSM or designee will audit all incidents of suspected/confirmed abuse allegations for the prior 3 months to ensure Area Agency on Aging was notified. PCHA and CSM were educated on July 27, 2023 on reporting suspected abused to the Area Agency on Aging.
3. , CSM
4. Target Completion Date: September 5, 2023
5. CSM or designee will audit all suspected/confirmed abuse allegations weekly X4 weeks and then monthly X2 or until substantial compliance is obtained to ensure Area Agency on Aging was notified. Corrective action plan will be monitor through QAPI process.

Licensee's Proposed Overall Completion Date: *09/05/2023*

Implemented (- 08/04/2023)

16c - Written Incident Report

3. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

Resident #1 slapped Resident #2's arm on [redacted] The home did not submit an incident report to the Department regarding the alleged abuse.

Plan of Correction ***Accept ([redacted] - 07/31/2023)***

1. The failure to submit an incident report specific to suspect/confirmed abuse allegation cannot be retroactively submitted to the Department.
2. CSM and PCHA, educated on July 27, 2023, on the timely submission to the Department of incident reports specific to suspected/confirmed abuse allegations.
3. [redacted], CSM
4. Target Completion date: September 5. 2023.
5. CSM or designee, will conduct audits weekly x4 then monthly x2 or until substantial compliance is obtained to ensure all suspected/confirmed abuse allegations were submitted to the Department in a timely manner. Corrective action plan will be monitor through QAPI process.

Licensee's Proposed Overall Completion Date: *09/05/2023*

Implemented [redacted] - 08/04/2023)

63a - First Aid/CPR Training

4. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

The home's census is 63. On [redacted] from [redacted] the home had only 1 staff person with First Aid and CPR (FA/CPR) certification in the home. Also, on [redacted] from [redacted] there were no staff persons in the home with FA/CPR certification. On [redacted] from [redacted] there were no staff in the home with FA/CPR certification

Plan of Correction ***Accept [redacted] - 07/31/2023)***

1. The tag cannot be retroactively corrected.
2. The CSM and PCHA were educated on July 27, 2023 on the importance of having 1 staff member who is CPR and First Aid Certified for every 50 residents in the home at all times.
3. [redacted], CSM
4. Target Completion Date: September 5, 2023
5. CSM or designee will conduct audit weekly X4 then monthly X2 or until substantial compliance is obtained to ensure 1 staff member who is CPR and First Aid Certified is on staff for every 50 residents in house. Corrective action plan will be monitor through QAPI process.

Licensee's Proposed Overall Completion Date: *09/05/2023*

63a First Aid/CPR Training *(continued)*

Implemented - 08/04/2023)

65a FS Orientation 1st Day

5. Requirements

2600.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

The home did not have documentation that the following staff persons received the trainings required under this regulation on their first day of employment:
Staff person A, hired ; Staff person B, hired Staff person C, hired

Plan of Correction ***Accept (- 07/31/2023)***

1. The tag cannot be retroactively corrected. Staff members B, and C will be given fire safety tour and education. Staff member A is a seasonal employee and will be given tour upon return.
2. Items under regulation 65a will be added to the orientation checklist for new hires. , our contracted culinary service, will follow the same orientation process to ensure compliance with this regulation. PCHA, CMS, ED, and Maintenance Director were educated on July 27, 2023 on regulation 2600.65a and the requirements to be compliant.
3. , CSM
4. Target completion date: September 5, 2023
5. Personal care new hires and contracted staff will be audited by CSM, Culinary Director and/or H.R. manager after each orientation x 3 months or until substantial compliance is obtained. Outcomes will be reported at QAPI for review and recommendation.

Licensee's Proposed Overall Completion Date: *09/05/2023*

Implemented (- 08/04/2023)

65b Rights/Abuse 40 Hours

6. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.

65b - Rights/Abuse 40 Hours *(continued)*

3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

The home did not have documentation that staff person B and C received the trainings required under this regulation within 40 hours of their first day of employment.

Plan of Correction ***Accept (- 07/31/2023)***

1. The tag cannot be retroactively corrected. Staff member B and C will complete annual training for resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act and Reporting of reportable incidents and conditions.
2. CSM and PCHA were educated on ensuring all required education is completed within 40 hours of employees first day of employment on July 27, 2023.
3. , CSM
4. Target completion date: September 5, 2023
5. Audits for prior 3 months of new hires were completed to ensure all employees completed required education within 40 hours of their first day of employment. CSM or designee will complete audits monthly x 3 months or until substantial compliance is achieved to ensure all required education is completed within 40 hours of employees first day of hire. Outcomes will be reported at QAPI for review and recommendation.

Licensee's Proposed Overall Completion Date: *09/05/2023*

Implemented (- 08/04/2023)

65e - 12 Hours Annual Training

7. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Staff person D did not have at least 12 hours of staff training completed for the 2022 training year.

Plan of Correction ***Accept - 07/31/2023)***

1. The tag cannot be retroactively corrected. Staff member D will be complete assigned annual training for training year 2023.
2. Staff were educated by CSM on July 27, 2023 on the requirement to complete assigned educations timely.
3. , CSM
4. Target completion date: September 5, 2023
5. Audits for completion of assigned education will be conducted by CSM or designee monthly x 3 months or until substantial compliance is obtained. Outcomes will be reported at QAPI for review and recommendation.

Licensee's Proposed Overall Completion Date: *09/05/2023*

Implemented (08/04/2023)

65g - Annual Training Content

8. Requirements

65g Annual Training Content *(continued)*

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.

Description of Violation

The following staff persons did not attend fire safety training conducted by a fire safety expert for the 2022 training year: Staff person D, E, and F.

Plan of Correction ***Accept (- 07/31/2023)***

1. Missed annual fire safety training cannot be retroactively corrected. Staff member D, E and F will complete annual in-person fire safety training.
2. Staff were educated on July 27, 2023 on the importance of each employee completing annual in-person fire safety training. CSM will develop a list of names for all those employees working in Personal Care and will mark each one off as they attend to ensure everyone receives the training. Training will be offered on various days at various times.
3. , CSM
4. Target completion date: September 5, 2023
5. CSM or designee will audit the sign-in sheet yearly, to ensure Personal Care employees attended the annual in-person fire safety training. A synopsis of the training will be attached. Outcomes will be reported at QAPI for review and recommendation.

Licensee's Proposed Overall Completion Date: *09/05/2023*

Implemented - 08/04/2023)

82c Locking Poisonous Materials

9. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

At approximately 10:45am on 6/27/23 the laundry room in the secure dementia unit (SDU) was left unlocked, leaving 2 gallons of laundry detergent accessible to the residents on the unit.
At approximately 10:45am on 6/27/23 a cleaning cart was left unlocked and unattended in the home's SDU. A bottle of Oxivir Five 16 concentrate was labeled if swallowed contact poison control immediately.
2 bottles of Listerine and a tube of Colgate toothpaste labeled if swallowed contact poison control immediately were in the unlocked cabinet in the bathroom of Room #113.
Resident #1 drank a sip of hand sanitizer on . The resident is unable to safely handle and identify poisonous materials.
All residents are unable to safely handle and identify poisonous materials.

Plan of Correction ***Accept - 07/31/2023)***

1. The tag cannot be retroactively corrected. The laundry room door in the SDU was immediately locked upon notification. Cleaning cart was immediately locked upon notification. Residents cabinet in room #113 was immediately locked upon notification. All hand sanitizers were removed off the unit and hand sanitizer wipes per

82c - Locking Poisonous Materials (continued)

put in place.

2. Staff were educated on July 27, 2023 on the importance of locking the laundry room door in the secure dementia unit (SDU) when not in the room, ensuring house-keeping cart is locked when unattended, ensuring all residents cabinets are locked, and the use of hand sanitizer wipes verses hand sanitizer gel.

3. [redacted], CSM

4. Target completion date: September 5, 2023

5. CSM or designee will complete audits weekly X4 then monthly X2 or until substantial compliance is achieved to ensure laundry room door is locked, house-keeping cart is locked when unattended, all resident cabinets are locked and the use of hand sanitizer wipes verse hand sanitizer gel. Outcomes will be reported at QAPI for review and recommendation.

Licensee's Proposed Overall Completion Date: *09/05/2023*

Implemented ([redacted] - 08/04/2023)

92 - Windows

10. Requirements

2600.

92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

During the initial walk through inspection the two exit doors at the far side of the home's auditorium were propped open without screen doors.

Plan of Correction ***Accept [redacted] - 07/31/2023)***

1. Tag cannot be retroactively be corrected. Doors were closed immediately upon notification.

2. Staff were educated on July 27, 2023 that exit doors are not to be propped open.

3. [redacted], CSM

4. Target completion date: September 5, 2023

5. CSM or designee will complete audits weekly X4 then monthly X2 or until substantial compliance is achieved to ensure no exit doors are propped open. Outcomes will be reported at QAPI for review and recommendation.

Licensee's Proposed Overall Completion Date: *09/05/2023*

Implemented ([redacted] - 08/04/2023)

93a - Handrails

11. Requirements

2600.

93.a. Each ramp, interior stairway and outside steps must have a well-secured handrail.

Description of Violation

The exit at the bottom of the stairwell identified as the kitchen stairs exit has an approximate 6 inch drop from the door. There was no handrail or assist bar installed next to this door to aid in exiting the home.

93a Handrails *(continued)*

Plan of Correction ***Accept [redacted] - 07/31/2023)***

1. Railing being installed outside door in question to aid in exiting the home.

2. PCHA and CSM will be given tour on July 31, 2023 with maintenance director of all of personal care home to observe all exit doors to ensure handrail or assist bar is outside of all exit doors with drop.

3. [redacted], PCHA

4. Target completion date: September 5, 2023

5. PCHA or designee and Maintenance Director will tour facility bi annually to ensure all handrails or assist bars at exit doors are present and in working order. Outcomes will be reported at QAPI for review and recommendation.

Licensee's Proposed Overall Completion Date: *09/05/2023*

Implemented [redacted] - 08/04/2023)

101j7 - Lighting/Operable Lamp

12. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

A bedside lamp or other source of lighting was not available from the bed in Room #102.

Plan of Correction ***Accept ([redacted] - 07/31/2023)***

1. Resident in room #102 was provided with a lighting source next to bed.

2. Staff were educated on July 27, 2023 that each resident should have an operable lamp or other source of lighting that can be turned on at bed side at all times.

3. [redacted], CSM

4. Target completion date: September 5, 2023

5. CSM or designee will complete audits weekly X4 then monthly X2 or until substantial compliance is achieved to ensure all residents have lighting source next to bed. Outcomes will be reported at QAPI for review and recommendation.

Licensee's Proposed Overall Completion Date: *09/05/2023*

Implemented ([redacted] - 08/04/2023)

103f - Refrigerator/Freezer Temps

13. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

The temperature of the refrigerator located in the SDU's kitchen area was 50 degrees Fahrenheit on 6/27/23 and 47 degrees Fahrenheit on 6/28/23.

103f - Refrigerator/Freezer Temps *(continued)*

Plan of Correction ***Accept [redacted] - 07/31/2023)***

1. The refrigerator temperature cannot retroactively be corrected. Temperature setting was adjusted to ensure refrigerator is holding a temperature of 40 degrees or below.
2. Staff were educated July 27, 2023 to check refrigerator temperatures daily and to ensure the temperature is at or below 40 degrees.
3. [redacted], CSM
4. Target completion date: September 5, 2023
5. CSM or designee will complete audits weekly X4 then monthly X2 or until substantial compliance is achieved to ensure refrigerator temperatures are at or below 40 degrees. Outcomes will be reported at QAPI for review and recommendation.

Licensee's Proposed Overall Completion Date: *09/05/2023*

Implemented ([redacted] 08/04/2023)

121a - Unobstructed Egress

14. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

The exit door near the laundry room in the Breidegam Center was blocked by a table, preventing immediate egress in the event of an emergency.
The exit door at the bottom of the kitchen stairs exit stairwell required excessive force to push open, preventing easy egress from the home.

Plan of Correction ***Accept [redacted] - 07/31/2023)***

1. Table blocking exit door near laundry room was removed immediately. Exit door at the bottom of the kitchen stairs exit stairwell is being replaced in the interim door was lubricated to allow door to open without excessive force.
2. PCHA and CSM will be given tour on July 31, 2023 with maintenance director of all of personal care home to observe all exit doors to ensure they open without excessive force.
3. [redacted], PCHA
4. Target completion date: September 5, 2023
5. PCHA or designee and Maintenance Director will tour facility bi-annually to ensure all exit doors are able to be opened without excessive force. Outcomes will be reported at QAPI for review and recommendation.

Licensee's Proposed Overall Completion Date: *09/05/2023*

Implemented [redacted] - 08/04/2023)

125a - Combustible Storage

15. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

125a - Combustible Storage *(continued)*

Description of Violation

A collection of dryer sheets were found behind the 2nd dryer in from the door in the home's main floor laundry room.

Plan of Correction ***Accept (- 07/31/2023)***

1. Dryer sheets were removed from behind the dryer in the home's main floor laundry room.
2. Staff educated on July 27, 2023 that combustibles and flammable materials such as dryer sheets may not be located near heat sources or hot water heaters.
3. , CSM
4. Target completion date: September 5, 2023
5. CSM or designee will audit behind all dryers in personal care home weekly X4 then monthly X2 or until substantial compliance is achieved to ensure there are no dryer sheets behind the dryers. Outcomes will be reported at QAPI for review and recommendation.

Licensee's Proposed Overall Completion Date: *09/05/2023*

Implemented (- 08/04/2023)

133.1 - Exit Signs

16. Requirements

2600.
133.1. Exit Signs - The following requirements apply for a home serving nine or more residents: Signs bearing the word ''EXIT'' in plain legible letters shall be placed at all exits.

Description of Violation

The 1st floor Buehrle Center exit doors to the left of the auditorium do not have an exit sign posted near the doors.

Plan of Correction ***Accept - 07/31/2023)***

1. Exit Sign on 1st floor Buehrle Center exit door to the left of the auditorium was replaced with new exit sign that shows there is an exit in both directions.
2. PCHA, CSM and Maintenance director were educated on July 27, 2023 that signs bearing the word EXIT in plain legible letters shall be place at all exits. PCHA and CSM will be given tour on July 31, 2023 with maintenance director of all of personal care home to observe all exit doors to ensure EXIT sign is placed at all exits.
3. , PCHA
4. Target completion date: September 5, 2023
5. PCHA or designee and Maintenance Director will tour facility bi-annually to ensure signs bearing the word EXIT in plain legible letters are placed at all exits. Outcomes will be reported at QAPI for review and recommendation.

Licensee's Proposed Overall Completion Date: *09/05/2023*

Implemented (- 08/04/2023)

141b1 - Annual Medical Evaluation

17. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #1's most recent documentation of medical evaluation (DME) was completed on , the previous DME

141b1 Annual Medical Evaluation (continued)

was completed on 12/7/21.
Resident #3's most recent DME was completed on [redacted], the previous DME was completed on [redacted].
Resident #4's most recent DME was completed on [redacted]

Plan of Correction ***Accept ([redacted] - 07/31/2023)***

1. Cannot retroactively correct missed DMEs for resident #1 and #3. DME for Resident #4 was updated on [redacted]
2. The CSM or designee will complete whole house audit to ensure DME's are up to date. Staff were educated that a resident shall have a medical evaluation (DME) at least annually on July 27, 2023.
3. [redacted], CSM
4. Target completion date: September 5, 2023
5. CSM or designee will audit DMEs weekly x 4, then monthly x2, or until substantial compliance is achieved to ensure DMEs are completed at least annually. Corrective action plan will be monitor through QAPI process.

Licensee's Proposed Overall Completion Date: *09/05/2023*

Implemented ([redacted] - 08/04/2023)

171b4 - Staff Training

18. Requirements

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
4. At least one staff member transporting or accompanying the residents shall have completed the initial new hire direct care staff person training as specified in § 2600.65 (relating to direct care staff training and orientation).

Description of Violation

The home did not have documentation that the drivers of the van used to transport residents, Staff person G and H, completed the department's required direct care competency training course.

Plan of Correction ***Accept ([redacted] - 07/31/2023)***

1. Staff member G completed the departments required direct care competency training course on July 12, 2023 and Staff member H completed on July 13, 2023.
2. PCHA and CSM were educated on July 27, 2023 that at least one staff member transporting or accompanying the residents shall have completed the initial new hire direct care staff person training.
3. [redacted], CSM
4. Target completion date: September 5, 2023
5. CSM or designee will audit all new hires for Personal Care monthly x3, or until substantial compliance is achieved to ensure departments required direct care competency training course are completed. Corrective action plan will be monitor through QAPI process.

Licensee's Proposed Overall Completion Date: *09/05/2023*

Implemented ([redacted] 08/04/2023)

182b - Prescription Medication

19. Requirements

182b - Prescription Medication *(continued)*

2600.
182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

1. A physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.
2. A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the home.
3. A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the home.
4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

The following staff persons' medication administration annual practicums were found to be overdue:

Staff person E- annual practicum was due to be completed by

Staff person I- annual practicum was due to be completed by

Staff person J- annual practicum was due to be completed by

Plan of Correction ***Accept (- 07/31/2023)***

1. Missed annual medication administration practicum training cannot be retroactively corrected. Staff member E is no longer employed with Diakon, staff member I completed annual practicum training on February 22,2023, and staff member J completed annual practicum training on April 6, 2023.

2. Staff were educated by CSM on July 27, 2023 on the specifics of regulation 182b so they can be proactive in working with the trainer to be in compliance.

3. , CSM

4. Target completion date: September 5, 2023

5. CSM or designee will audit all med-tech compliance monthly x 3 or until substantial compliance is obtained. Outcomes will be reported for review and recommendation at QAPI.

Licensee's Proposed Overall Completion Date: *09/05/2023*

Implemented - 08/04/2023)

183d - Prescription Current

20. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

Resident #3 has an order for every 12 hours as needed. The medication cart contained a blister pack of tablets with a pharmacy label stating administer 3 times daily. There is no current straight order for the medication

Plan of Correction ***Accept (- 07/31/2023)***

1. Medication was removed immediately upon discovery.

2. Staff educated on July 27, 2023 that only current prescriptions, OTC, sample and CAM for individuals living in the home may be kept in the home. When a medication is discontinued that medication must be removed from the cart.

183d - Prescription Current (continued)

3. [redacted], CSM

4. Target completion date: September 5, 2023

5. CSM or designee will audit compliance weekly X4 then monthly x 3 or until substantial compliance is obtained. Outcomes will be reported for review and recommendation at QAPI.

Licensee's Proposed Overall Completion Date: *09/05/2023*

Implemented (- 08/04/2023)

184a - Resident's Meds Labeled

21. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #5 has an order for [redacted] tablets to be administered 3 times daily and held if the Systolic Blood Pressure (SBP) is less than [redacted] or heart rate (HR) is less than [redacted] The pharmacy label for this medication did not include the parameter for the medication.

Plan of Correction ***Accept (- 07/31/2023)***

1. Medication labels for resident #5 were corrected immediately upon surveyor notification.

2. Staff were educated by CSM on regulation 184.a and the importance to ensure all parts of the label are on every medication correctly.

3. [redacted], CSM

4. Target completion date: September 5, 2023

5. Audits will be conducted weekly x 4 weeks and then monthly x 2 or until substantial compliance is obtained, by the CSM or Designee to ensure compliance. Outcomes will be reported at QAPI for review and recommendation.

Licensee's Proposed Overall Completion Date: *09/05/2023*

Implemented (- 08/04/2023)

185a - Implement Storage Procedures

22. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

The following residents' glucometers were not calibrated to the correct date and/or time:

Resident #6, Resident #7. Resident #8.

Resident #6 has an order for blood glucose readings twice daily. On [redacted] the glucometer noted a reading of [redacted], however the medication administration record (MAR) noted a reading of [redacted]

The following PRN medications were not found in the medication carts for these residents:

Resident #3— [redacted]

Resident 8— [redacted]

185a - Implement Storage Procedures (continued)

Plan of Correction ***Accept - 07/31/2023)***

1. Resident #6, #7, and #8 glucometer was calibrated to show correct date and time. Cannot retroactively correct glucometer entry error. PRN's for resident #3 were discontinued due to non-use and for resident #8 and were discontinued for non-use and obtained and is in med cart.
2. The CSM or designee will complete medication cart audit to ensure all resident who have orders for PRN medications have them available in medication cart. The CSM or designee will provide staff education on how and when to calibrate glucometers, transcribing blood glucose readings to the MAR and ensuring all PRN medications are available for resident use.
3. , CSM
4. Target completion date: September 5, 2023
5. CSM or designee will audit medication cart weekly x 4, then monthly x2, or until substantial compliance is achieved to ensure all PRN medication orders are available in medication cart for resident use. Audit will be completed weekly X4 then monthly X2 to ensure the calibration of glucometers and to ensure the transcription of blood glucose is documented correctly in MAR. Corrective action plan will be monitor through QAPI process.

Licensee's Proposed Overall Completion Date: *09/05/2023*

Implemented - 08/04/2023)

187d - Follow Prescriber's Orders

23. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident # 5 has an order for tablets three times daily with an order to hold if the SBP is less than or the HR is less than . Resident #5 also has an order for two times daily with the same parameter. On the following dates and times no blood pressure and/or HR was recorded and the medication was not administered:

Resident #8 has an order for two times daily with an order to hold if the SBP is less than . On the following dates and times no blood pressure was recorded and the medication was not administered:

Plan of Correction ***Accept - 07/31/2023)***

1. Medication errors cannot be retroactively corrected.
2. Staff were educated by CSM on July 27, 2023 on the importance of following the six-rights of medication administration paying special attention to parameters and the documentation of parameters.
3. , CSM
4. Target completion date: September 5, 2023
5. CSM or Designee will audit the MAR's weekly for 4 weeks then monthly x 2 or until substantial compliance is obtained to ensure all medications with parameters were administered correctly. Outcomes will be reported at the

187d - Follow Prescriber's Orders (continued)

monthly QAPI for review and recommendation.

Licensee's Proposed Overall Completion Date: *09/05/2023*

Implemented [redacted] - 08/04/2023)

225c - Additional Assessment

24. Requirements

2600.
225.c. The resident shall have additional assessments as follows:

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident #4's most recent assessment portion of the resident assessment and support plan (RASP) was completed on [redacted]

Plan of Correction ***Accept ([redacted] - 07/31/2023)***

1. The missed Support Plan cannot be retroactively corrected.
2. Resident #4 support plan was completed [redacted]. Staff were educated on the need to complete support plan annually, with significant change in condition, and at the request of the department upon cause to believe that an update is required.
3. [redacted], CSM
4. Target completion date: September 5, 2023
5. Audits will be conducted by CSM or designee weekly x 4 or until substantial compliance is obtained. Outcomes will be reported at QAPI for review and recommendation.

Licensee's Proposed Overall Completion Date: *09/05/2023*

Implemented ([redacted] - 08/04/2023)

227d - Support Plan Medical/Dental

25. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident #3 has an order for a low sodium mechanical soft diet. The resident assessment and support plan (RASP) dated [redacted] notes the resident does not have any dietary needs.
Resident #9 utilizes a grab assist bar on the resident's bed. The residents RASP dated [redacted] doesn't indicate the use of the enabler bar or how the home will maintain the bar.

227d - Support Plan Medical/Dental *(continued)*

Plan of Correction ***Accept [redacted] - 07/31/2023)***

1. The Resident Assessment and Support Plan (RASP) was update for resident #3 and #9.
2. Staff were educated on 227.d. House audit completed to ensure that RASP are updated for any residents who have altered diet or utilize grab assist bar.
3. [redacted], CSM
4. Target completion date: September 5, 2023
5. Audits will be conducted weekly x 4 weeks and then monthly x 2 or until substantial compliance is obtained, by the CSM or Designee to ensure compliance. Outcomes will be reported at QAPI for review and recommendation.

Licensee's Proposed Overall Completion Date: *09/05/2023*

Implemented [redacted] - 08/04/2023)

234a - Admission Support Plan

26. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #10 was admitted to the homes SDCU on [redacted] the resident assessment and support plan (RASP) was not completed until [redacted]

Plan of Correction ***Accept ([redacted] 07/31/2023)***

1. The missed RASP cannot be retroactively corrected.
2. PCHA and CSM were educated that within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the residents record.
3. [redacted], CSM
4. Target completion date: September 5, 2023
5. Audits will be conducted monthly x 3 or until substantial compliance is obtained, by the CSM or Designee to ensure all new admissions have RASP completed in a timely manner. Outcomes will be reported at QAPI for review and recommendation.

Licensee's Proposed Overall Completion Date: *09/05/2023*

Implemented ([redacted] - 08/04/2023)

234d - Support Plan Revision

27. Requirements

2600.
234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

Resident #1's RASP dated [redacted] notes the resident doesn't have any problems with agitation and aggression. Nursing notes for the month of June indicate the resident is combative with the residents and staff. The resident hit Resident #2 on the arm on [redacted]. On [redacted] the resident grabbed resident #11's left arm and twisted it which caused bruising.

234d Support Plan Revision (continued)

The resident assessment and support plan (RASP) has not been updated to reflect the residents' current behaviors and how the home will manage them.

Plan of Correction ***Accept (- 07/31/2023)***

1. Resident #1 RASP has been update to show residents change in behaviors..
2. Staff were educated that the support plan shall be revised at least annually and as the resident's condition changes.
3. , CSM
4. Target Completion Date: September 5, 2023
5. CSM or designee will conduct audits to ensure Rasp are updated when new behaviors or change in condition are identified weekly x4, then monthly x 2, or until substantial compliance is achieved. Corrective action plan will be monitored through QAPI process.

Licensee's Proposed Overall Completion Date: *09/05/2023*

Implemented - 08/04/2023)